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**State:** Arkansas **Filing Company:** Philadelphia American Life Insurance Company  
**TOI/Sub-TOI:** L07I Individual Life - Whole/L07I.101 Fixed/Indeterminate Premium - Single Life  
**Product Name:** L18.SM.AP  
**Project Name/Number:** L18.SM.AP/L18.SM.AP

## Filing at a Glance

Company: Philadelphia American Life Insurance Company  
Product Name: L18.SM.AP  
State: Arkansas  
TOI: L07I Individual Life - Whole  
Sub-TOI: L07I.101 Fixed/Indeterminate Premium - Single Life  
Filing Type: Form  
Date Submitted: 01/11/2013  
SERFF Tr Num: NELI-128843600  
SERFF Status: Closed-Approved-Closed  
State Tr Num:  
State Status: Approved-Closed  
Co Tr Num: L18.SM.AP  
  
Implementation: On Approval  
Date Requested:  
Author(s): John Mays  
Reviewer(s): Linda Bird (primary)  
Disposition Date: 01/17/2013  
Disposition Status: Approved-Closed  
Implementation Date:

State Filing Description:

**State:** Arkansas  
**TOI/Sub-TOI:** L071 Individual Life - Whole/L071.101 Fixed/Indeterminate Premium - Single Life  
**Product Name:** L18.SM.AP  
**Project Name/Number:** L18.SM.AP/L18.SM.AP

**Filing Company:** Philadelphia American Life Insurance Company

## General Information

Project Name: L18.SM.AP  
Project Number: L18.SM.AP  
Requested Filing Mode: Review & Approval  
Explanation for Combination/Other:  
Submission Type: New Submission  
Overall Rate Impact:

Status of Filing in Domicile:  
Date Approved in Domicile:  
Domicile Status Comments:  
Market Type: Individual  
Individual Market Type:  
Filing Status Changed: 01/17/2013  
State Status Changed: 01/17/2013  
Created By: John Mays  
Corresponding Filing Tracking Number:

Deemer Date:  
Submitted By: John Mays

### Filing Description:

NEW FORMS ONLY FILING – APPLICATION FORM FILING FOR INDIVIDUAL WHOLE LIFE INSURANCE  
PHILADELPHIA AMERICAN LIFE INSURANCE COMPANY  
NAIC # 67784 / FEIN # 74-1952955

Form Number / Description  
L18.SM.AP.PAL / Application for Life Insurance

We are submitting the captioned form as an exempt filing or for your approval. This form is new and not intended to replace any previously filed forms. It will be used with our companies Standard Plan Individual Whole Life Insurance form number approved by your state on , filing number or SERFF tracking number .

## Company and Contact

### Filing Contact Information

John Mays,  
11720 Katy Fwy., Ste. 1700  
Houston, TX 77079

jmays@neweralife.com  
281-368-7178 [Phone]

### Filing Company Information

Philadelphia American Life Insurance Company	CoCode: 67784	State of Domicile: Texas
200 Westlake Park #1200	Group Code: 520	Company Type:
Houston, TX 77079	Group Name:	State ID Number:
(281) 368-7200 ext. [Phone]	FEIN Number: 74-1952955	

## Filing Fees

Fee Required?	Yes
Fee Amount:	\$50.00
Retaliatory?	No
Fee Explanation:	
Per Company:	No

**SERFF Tracking #:** NELI-128843600

**State Tracking #:**

**Company Tracking #:** L18.SM.AP

**State:** Arkansas

**Filing Company:** Philadelphia American Life Insurance Company

**TOI/Sub-TOI:** L071 Individual Life - Whole/L071.101 Fixed/Indeterminate Premium - Single Life

**Product Name:** L18.SM.AP

**Project Name/Number:** L18.SM.AP/L18.SM.AP

Company	Amount	Date Processed	Transaction #
Philadelphia American Life Insurance Company	\$50.00	01/11/2013	66487274

<b>SERFF Tracking #:</b>	NELI-128843600	<b>State Tracking #:</b>		<b>Company Tracking #:</b>	L18.SM.AP
<b>State:</b>	Arkansas	<b>Filing Company:</b>	Philadelphia American Life Insurance Company		
<b>TOI/Sub-TOI:</b>	L071 Individual Life - Whole/L071.101 Fixed/Indeterminate Premium - Single Life				
<b>Product Name:</b>	L18.SM.AP				
<b>Project Name/Number:</b>	L18.SM.AP/L18.SM.AP				

## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	01/17/2013	01/17/2013

### Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Correction to Form being used with.	Note To Reviewer	John Mays	01/14/2013	01/14/2013
From to be used with.	Note To Reviewer	John Mays	01/14/2013	01/14/2013

<b>SERFF Tracking #:</b>	NELI-128843600	<b>State Tracking #:</b>		<b>Company Tracking #:</b>	L18.SM.AP
<b>State:</b>	Arkansas	<b>Filing Company:</b>	Philadelphia American Life Insurance Company		
<b>TOI/Sub-TOI:</b>	L071 Individual Life - Whole/L071.101 Fixed/Indeterminate Premium - Single Life				
<b>Product Name:</b>	L18.SM.AP				
<b>Project Name/Number:</b>	L18.SM.AP/L18.SM.AP				

## Disposition

Disposition Date: 01/17/2013

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Life & Annuity - Acturial Memo		No
Form	Application		Yes

**State:** Arkansas **Filing Company:** Philadelphia American Life Insurance Company  
**TOI/Sub-TOI:** L071 Individual Life - Whole/L071.101 Fixed/Indeterminate Premium - Single Life  
**Product Name:** L18.SM.AP  
**Project Name/Number:** L18.SM.AP/L18.SM.AP

## Note To Reviewer

**Created By:**

John Mays on 01/14/2013 11:24 AM

**Last Edited By:**

Linda Bird

**Submitted On:**

01/17/2013 09:55 AM

**Subject:**

Correction to Form being used with.

**Comments:**

It will be used with our companies Standard Plan Individual Whole Life Insurance form number L-0018.PAL.AR approved by your state on 11/8/2011, filing number or SERFF tracking number NELI-127778249.

**State:** Arkansas**Filing Company:** Philadelphia American Life Insurance Company**TOI/Sub-TOI:** L071 Individual Life - Whole/L071.101 Fixed/Indeterminate Premium - Single Life**Product Name:** L18.SM.AP**Project Name/Number:** L18.SM.AP/L18.SM.AP

## Note To Reviewer

**Created By:**

John Mays on 01/14/2013 11:15 AM

**Last Edited By:**

Linda Bird

**Submitted On:**

01/17/2013 09:55 AM

**Subject:**

From to be used with.

**Comments:**

It will be used with our companies Standard Plan Individual Whole Life Insurance form number approved by your state on 11/8/2011, filing number L-0018.PAL.AR or SERFF tracking number NELI-127778249.

<b>State:</b>	Arkansas	<b>Filing Company:</b>	Philadelphia American Life Insurance Company
<b>TOI/Sub-TOI:</b>	L071 Individual Life - Whole/L071.101 Fixed/Indeterminate Premium - Single Life		
<b>Product Name:</b>	L18.SM.AP		
<b>Project Name/Number:</b>	L18.SM.AP/L18.SM.AP		

## Form Schedule

Lead Form Number: L18.SM.AP								
Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1		Application	L18.SM.AP. PAL	AEF	Initial		40.000	L18.SM.AP.PAL.pdf

### Form Type Legend:

<b>ADV</b>	Advertising	<b>AEF</b>	Application/Enrollment Form
<b>CER</b>	Certificate	<b>CERA</b>	Certificate Amendment, Insert Page, Endorsement or Rider
<b>DDP</b>	Data/Declaration Pages	<b>FND</b>	Funding Agreement (Annuity, Individual and Group)
<b>MTX</b>	Matrix	<b>NOC</b>	Notice of Coverage
<b>OTH</b>	Other	<b>OUT</b>	Outline of Coverage
<b>PJK</b>	Policy Jacket	<b>POL</b>	Policy/Contract/Fraternal Certificate
<b>POLA</b>	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	<b>SCH</b>	Schedule Pages





# Application for Whole Life Insurance (Form L-0018)

PHILADELPHIA AMERICAN LIFE INSURANCE COMPANY • P.O. BOX 4884, HOUSTON, TX 77210-4884 • 281-368-7200 • 1-877-368-4692

## Section A General Information (Please Print)

Proposed Insured's Name:		<input type="checkbox"/> Male <input type="checkbox"/> Female		Requested Effective Date:	
Daytime Phone:		Social Security #:			
Address:		City:		State:	Zip Code:
Birthdate:	State or Country of Birth:		Height (ft./in.):		Weight (lbs.):
Primary Beneficiary:		Relationship:	Address:		
Contingent Beneficiary:		Relationship:	Address:		
Owner (If other than Proposed Insured):		Relationship:	Address:		
Will proposed insurance replace any existing life insurance or annuity? .....					<input type="checkbox"/> Yes <input type="checkbox"/> No
Existing Coverage Insurer's Name:		Policy/Certificate #:	Plan Type:	Maximum Benefits:	Termination Date:
Within the past 24 months, have you used tobacco in any form? .....					<input type="checkbox"/> Yes <input type="checkbox"/> No

## Section B Standard Level Benefit Qualifying Section

1. Are you currently confined, or has confinement been recommended, to a bed, hospital, nursing facility, or other care facility, or do you need the assistance of a wheelchair, cane or walker for any daily activity? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Within the past 2 years, have you been hospitalized 2 or more times, or been confined to a nursing home for a total of 2 weeks or longer? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Within the past 2 years, have you been advised to have surgery which has not yet been done? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Within the past 5 years, have you consulted for treatment, sought treatment, had treatment recommended, received treatment, been hospitalized for, or taken or been advised by a physician to take prescription drugs (excluding drugs for high blood pressure) for the following conditions:	
a. Heart or vascular conditions including but not limited to heart attack, open heart surgery, placement of a stent, heart valve replacement, angioplasty, aneurysm, congestive heart failure, enlarged heart, cardiovascular heart disease, peripheral vascular disease, coronary artery disease, irregular heartbeat or stroke? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Alzheimer's disease, Parkinson's disease, senile dementia, organic brain disorder, any neurological disorder or other senility disorder? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. Any respiratory condition including but not limited to Chronic Obstructive Pulmonary Disease (COPD), asthma, emphysema or use of inhalers, nebulizers or oxygen? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. Internal cancer, leukemia, melanoma, Hodgkin's disease, insulin dependent diabetes, Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), chronic kidney disease, kidney/renal failure, kidney/renal dialysis, cirrhosis of the liver, organ transplant (except cornea) or amputation? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. In the past 12 months have you had placement of a pacemaker or had a joint replacement? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Within the past 24 months, have you had, or been advised to receive treatment for (including prescription medications):	
a. Alcohol and/or drug use? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Insulin Dependent Diabetes? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. Multiple sclerosis or systemic lupus erythematosus? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. Lung disease or disorder, Liver disease or disorder, Transient Ischemic Attack (TIA)? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Within the past 24 months, have you been diagnosed as having or been treated for (including prescription medications) Mental Incapacity? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Have you ever tested positive for the Human Immunodeficiency Virus (HIV)? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Have you had an application for life insurance rejected in the past 6 months? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Does your weight exceed the maximum weight on the Maximum Weight Table below? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No

Height	4'11"	5'0"	5'1"	5'2"	5'3"	5'4"	5'5"	5'6"	5'7"	5'8"	5'9"	5'10"	5'11"	6'0"	6'1"	6'2"	6'3"	6'4"	6'5"
Weight (lbs)	200	205	215	220	225	230	235	240	250	255	265	270	280	285	295	305	315	320	335

Name, Address and Phone Number of Personal Physician:

Section C Premium Information		
Face Amount: \$ _____	Premium: \$ _____	
Automatic Premium Loan:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Premium Mode:	<b>PAC:</b> <input type="checkbox"/> Monthly - from account indicated below <b>Direct Bill:</b> <input type="checkbox"/> Annual <input type="checkbox"/> Semi-Annual	

I hereby apply to Philadelphia American Life Insurance Company for coverage under a Policy to be issued in reliance upon the written answers to the questions in this Application which I have answered to the best of my knowledge and belief. I understand and agree that (1) the coverage shall not take effect unless the Application has been accepted and approved in writing by the Company and until the Effective Date of my coverage under the Policy and (2) my coverage will not become effective until all necessary underwriting information has been received and reviewed by the Home Office and that the requested Effective Date may be delayed if the Home Office requires additional medical information to process my Application and (3) the agent does not have the authority to waive a complete answer to any question in the Application, pass on insurability, make or alter any part of the contract, or waive any of the Company's other rights or requirements. I understand and agree that the falsity of any answer or statement in this Application may bar the right to recover under the Policy if such answer materially affects the acceptance of the risk or hazard assumed by the Company. The Company may rely upon this Application and all of the information contained herein.

I hereby authorize and request any physician, hospital, dentist, pharmacy, pharmacy benefit manager, individual, employer, insurance company, law enforcement agency, governmental agency or other entity to permit bearer or representative of Philadelphia American Life Insurance Company to view, copy, be furnished a copy or be given details of all record information in connection with any past or present illnesses, financial records, employment records and/or police records. This authorization is to include, but is not limited to information pertaining to diagnosis, care or treatment for psychiatric disorder, drug and alcohol abuse, treatment or prescriptions, testing and/or treatment of Human Immunodeficiency Virus (HIV) (AIDS virus) and/or sexually transmitted diseases. Health information obtained will not be re-disclosed without your authorization unless permitted by law, in which case it may not be protected under federal privacy rules. The results of a Human Immunodeficiency Virus-related test shall be confidential and we cannot release or disclose this information except in certain circumstances permitted by law. Any physician, practitioner, hospital, clinic, other medical or medically related facility, the Veterans Administration, my employer or consumer reporting agency or insurance company who possesses information of care, treatment or advice of me, my family, or our health may furnish such information to Philadelphia American Life Insurance Company or its representative or its reinsurers upon presenting this authorization or a photocopy. Philadelphia American Life Insurance Company or its reinsurers may make a brief report available regarding me or my dependents to other companies to whom I have applied or may apply. I understand that I may revoke this authorization at any time by writing to Philadelphia American Life Insurance Company and that I or my representative is entitled to receive a copy of this authorization form upon request. This authorization shall remain in effect for twenty four (24) months from the date this authorization is signed.

I acknowledge receipt of the Notice Regarding Replacement form if this is a replacement. I have received and read the conditional receipt. It has been explained to me by the agent. I understand and agree to all the conditions and limitations.

Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may commit a fraudulent insurance act, which is a crime and which may subject such person to criminal and/or civil penalties.

<u>X</u> _____	_____	_____
Proposed Insured's Signature	Signed at (City and State)	Date
<u>X</u> _____	_____	_____
Witness (Licensed Resident Agent)	Owner, if other than Proposed Insured	Date

### Pre-Authorization (PAC) Check Payment Plan (Attach voided check or deposit slip)

Your Name *(as it appears on your bank account)* \_\_\_\_\_  
 Account Number \_\_\_\_\_  
 Name of Financial Institution (Bank) \_\_\_\_\_  
 Address of Financial Institution (Bank) \_\_\_\_\_

I hereby authorize Philadelphia American Life Insurance Company to initiate debit entries to my account indicated above, and I authorize the Financial Institution named above to charge the amount of such entries to my account. I further authorize Company to initiate credits to my account to correct errors, and Institution to deposit any such corrections to my account.

This authority is to remain in full force and effect until I revoke the agreement as hereafter provided. Any revocation is effective only after Company has received written notice from me to terminate this agreement in such time and manner to afford a reasonable opportunity to act upon the notice. I have the right to stop payment of a debit entry by notification to Institution in such time and manner to afford a reasonable opportunity to act prior to charging the account.

<u>X</u> _____	<u>X</u> _____	_____
Signature	Second Signature for Joint Account	Date

Telephone Interview Information

Philadelphia American Life Insurance Company reserves the right to conduct a telephone interview ("Personal History Interview") directly with the Proposed Insured. Please assist us in completing the interview by providing the following information:

Best time to call: ☐ AM ☐ PM Phone: ( ) - ☐ Home ☐ Work

Agent Information

I certify that I have personally asked each question on the application to the applicant and have truly and accurately recorded the answers provided. To the best of my knowledge, replacement of an existing policy ☐ IS ☐ IS NOT involved in this transaction.

Agent \_\_\_\_\_ Percent \_\_\_\_\_ License No. \_\_\_\_\_  
Agent \_\_\_\_\_ Percent \_\_\_\_\_ License No. \_\_\_\_\_

Tear Along the Dotted Line

Conditional Receipt

Received from: \_\_\_\_\_ for Life Insurance.

Payment is: \$ \_\_\_\_\_ ☐ Cash ☐ Check

**IMPORTANT:** No insurance will be effective until your application is approved and the policy is issued. The agent cannot accept risk or waive any of the Company's rights or requirements. This receipt is not valid unless it is signed by an agent of the Company, the Proposed Insured and the Owner.

All premium checks shall be made payable to Philadelphia American Life Insurance Company  
Do not make checks payable to the agent or leave the payee blank  
SIGNATURE IS REQUIRED

**X** \_\_\_\_\_ **X** \_\_\_\_\_ **X** \_\_\_\_\_  
Proposed Insured's Signature Date Agent Owner, if other than Proposed Insured

<b>SERFF Tracking #:</b>	NELI-128843600	<b>State Tracking #:</b>		<b>Company Tracking #:</b>	L18.SM.AP
<b>State:</b>	Arkansas	<b>Filing Company:</b>	Philadelphia American Life Insurance Company		
<b>TOI/Sub-TOI:</b>	L071 Individual Life - Whole/L071.101 Fixed/Indeterminate Premium - Single Life				
<b>Product Name:</b>	L18.SM.AP				
<b>Project Name/Number:</b>	L18.SM.AP/L18.SM.AP				

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification		
Comments:			
Attachment(s):			
Readability Certification.PAL.pdf			

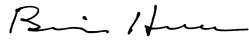
## READABILITY CERTIFICATION

I hereby certify that the forms listed below meet the minimum reading ease score on a Flesch test basis:

**New Form Number**

**Readability Score**

L18.SM.AP.PAL..... 40



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Brian Hull, AIRC  
Vice President  
Product Development and Compliance  
Philadelphia American Life Insurance Company